CHANGING PATTERNS OF HEALTH

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the medical missionary

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CHANGING HEALTH PATTERNS

EDITORIAL

Witchcraft cures: beaks of birds, skins of mice, skulls of monkeys, and snakes to cure Africa's ills.

"Most of the great ancient civilizations flourished in tropical or sub-tropical climates," says Edward Tomlinson in a recent book.* The Near East was the cradle of several. So were India, Burma, and the lands of southwest Asia. Great were the Pharaohs but malaria ravaged and outlived their empire. Great too, was Alexander and his empire but he too, fell to the tiny barb of the mosquito and is believed to have died of malaria besides the waters of Babylon. Indeed, most of the old civilizations, faded largely because of their inability to cope with disease and pestilence, especially those peculiar to hot climates. Today, with the modern miracles of medical science and sanitation we now have the weapons to overcome these mortal enemies of the tropics.

Medical geographers today agree that the patterns of diseases, and health measures that can be applied to them, vary greatly in different parts of the world. Disease they say must be understood on an area basis. Many link it directly with climatic conditions. J.C.M. Burdin, a Frenchman already expressed this theory way back in 1843. "Kingdoms of disease" he says, "like plant and animal kingdoms are distributed in particular countries and climates. Man is not born, does not live, suffer, die, in the same way in different parts of the world. Conception, birth, and life, sickness and death, all change with climate and soil, with the seasons and months, with race and nationality."

To a large degree, the physical elements of climate govern man's cultures. The houses people live in, the food they eat, the way they cook it, what type of clothing they wear all originate because of climate and have a bearing on their health and the type of diseases they contract.

In the East we see that cultural traits and religious ideas influence disease patterns in varying ways. The common bowls used in Buddhist temples for washing hands spread eye, skin and other diseases. The vegetarian diet of the Hindu, which is perfectly agreeable to the rich, who can afford to supplement their lack of animal protein with milk, eggs and butter, are disastrous for the poor. The story of the spread of cholera through religious pilgrimages of both Hindus and Muslims, is well known.

Dr. Jacques May, who made a special study of disease patterns in the East and Africa divides the world into four broad regions showing the diseases peculiar to each: (Medical Geography)

1. In the Far East, he says, where uncooked crab and fish are the main articles of diet—one finds the diseases connected with the liver fluke, the lung fluke, the intestinal tape worm.

2. Westward over the vast expanses of China, India, and Arabia, the shores of the Red Sea and Tropical Africa, where people live close to the soil, all the diseases of the intestine—amoebic dysentery, bacillary dysentery, all the intestinal worms are found. In the Yangtze and the Ganges Valley, Madras and Bombay, we find the centuries old endemic foci (home) of cholera. The land of soil pollution is also the land of rice; and where rice is eaten for the most part the people have beri-beri.

3. In Africa we have the diseases correlated to the tsetse fly, the trypanosomiasis. The Atlantic shore of Africa, the shores of Central and South America are the realm of yellow fever.

4. In the Americas we find the great contrasts between the two regions —

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* *Look Southward, Uncle*

** *Medical Geography*

Central and South America, and North America. In most areas of the southern region the disease picture is still very serious whereas in the north, a developed area, man has altered the picture.

Looking over this world map it is evident that it is in the vast undeveloped areas of the world that the tropical and communicable diseases still hold their sway and take millions of lives.

What makes or causes these countries to be undeveloped countries? For most of the tropics, one can say it is the very fact of their medical geography. Poor soil produces poor food, micro-organisms finding a suitable climate and host produce poor health, both are the cause of poor working efficiency, all operating in a vicious circle. With these terrific handicaps people cannot develop their culture. They are hardly in a position to establish institutions which would enable them to raise the standard of living, organize sanitary campaigns, and achieve public health.

CAN THE PATTERNS OF DISEASE BE CHANGED IN ASIA AND AFRICA? Yes, they can, and are being *changed.*

Africa is changing. The most spectacular modern evolution is taking place in Africa where amidst bulldozers, cranes and cement mixers, concrete structures seem to rise overnight. But in the depths of the Bush, in the villages, in the streets, in the offices of administration, a battle for health against the scourges of malaria, yaws, sleeping sickness, yellow fever, etc. is being waged. This is a decisive struggle wherein traditional ideas and patterns are being attacked and overthrown. Enemy Number One is the witch doctor. While Africans on the whole are putting more and more trust in the modern physician and his medicine, yet many in the rural areas, still go to the witch doctor, and some consult both.

India is changing. India has made great health strides through her Five Year Plans especially in her campaign against T.B. and for malaria control. But India like most of the underdeveloped countries needs thousands more hospitals, more medical schools, more trained health workers. . . Most of the doctors are located in the cities, while 85% of the people live in the villages. The villages and cities are further separated by poverty, ignorance, lack of education and by the observance of long established customs which are outmoded or harmful. Many village women, Hindu as well as Muslim, will not accept a male physician especially for a confinement case. Many still prefer to depend on the illiterate and unhygienic ministrations of an untrained midwife. A start has been made in achieving public health but it will take years of education and re-education, and penetration, and much cooperation before the health of the masses in the 700,000 villages will be notably affected.

All the countries of Asia and Africa are passing through a phase which could be described as an accelerated evolution. Traditional ways of life are being replaced by a civilization in which modern techniques play a prominent role. Indian, African, and Pakistani governments are becoming more health conscious as they take their destinies into their own hands.

How to go about improving the health situation with limited resources is their great problem since economic costs of applying such measures on a large scale remains a formidable barrier even for governments. Also there is a scarcity

of personnel. While feverishly trying to equip and train local health workers with new and skilled techniques, they look to the developed areas of the world for skilled know-how in their gigantic battle against poverty and disease.

Even for our own sakes we cannot remain indifferent to this struggle. For today, we realize that the threat of disease in one country is a threat to the world. A few centuries ago the Black Death took some ten years to travel from the Orient to western Europe; today an influenza outbreak in a remote Chinese village can spread around the world within a week. This was brought out in a cartoon not long ago that showed an old Chinese couple in a remote village of China. The man is blowing his nose, and the woman says: "Little did you know when you started those few sneezes some months ago that you would become a world figure." Referring of course, to Asian Flu which has travelled far and wide from Asia.

Change in India. Indian midwives are now being trained. Here one sterilizes her new equipment before using.

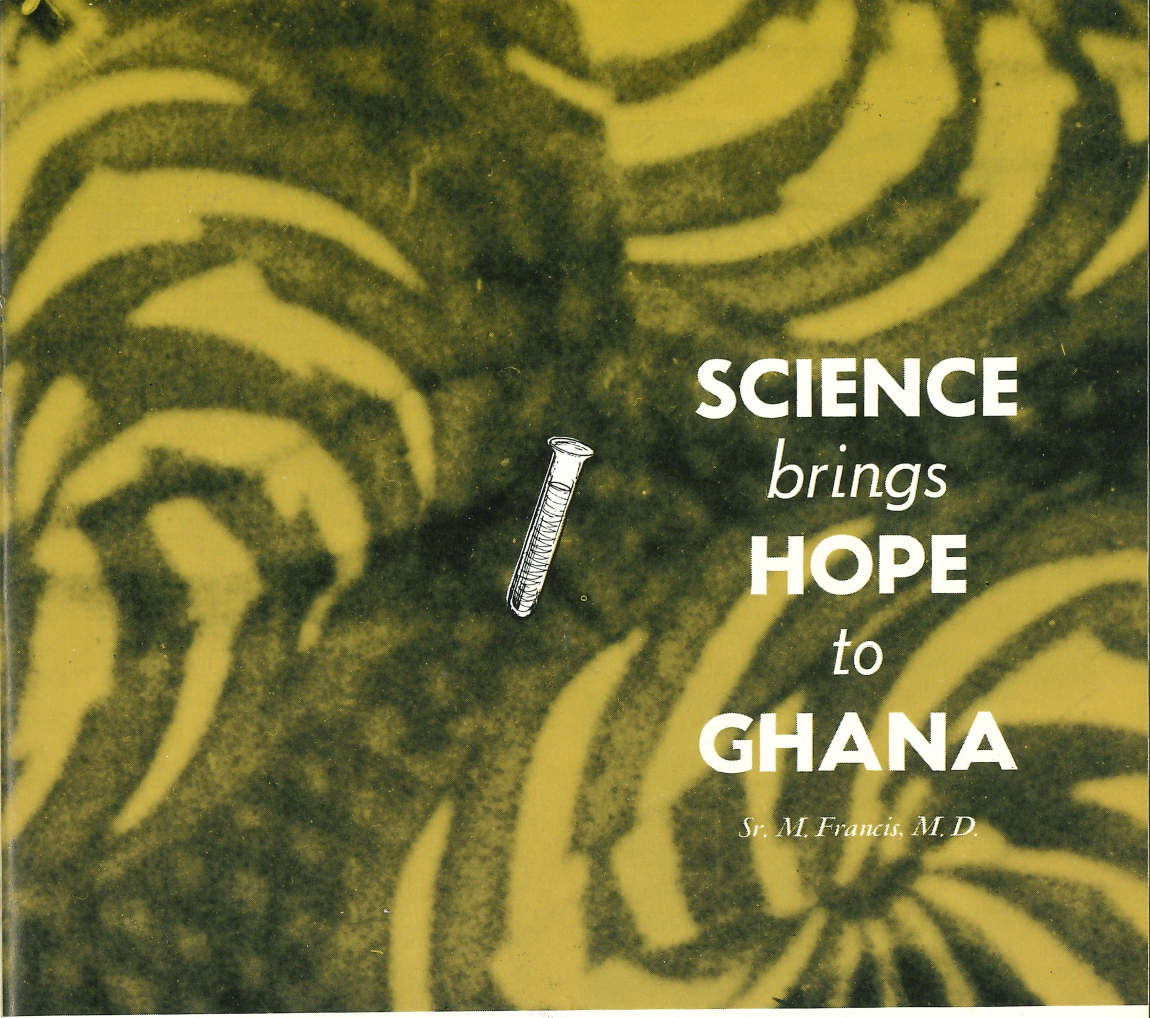
We of the west, could, if we would put our minds and resources to it, wipe out from the face of the earth the scourges of malaria, cholera, yellow and typhus fevers. The new methods and means of control that are available are far more effective than anyone could imagine a few years ago. Just think of the antibiotics, the powerful new insecticides and all the new synthetic chemicals we have today.

We could if we would—then why do we hesitate? We cannot expect the peoples of the world who today are such close neighbors of ours to be content to remain forever in misery just because they have been born in the wrong country and climate . . . We of the West, not only possess, but control most of the wealth of land, resources, health, and food of the world. Do we Christians of the West have any obligation to take notice of their misery and malnutrition? Are they not part of our universal family? Is not God their Father also, and are not they and we—truly brothers in Christ? We *are* our brother's keepers!

Does it not disturb us that one day we will be called upon to give an account of how we have reacted to our neighbor's physical needs? That whether we have fed the hungry, cared for the sick, and what we have done, or not done, to the least of His brethren, will be the "test" the criterion, as to whether or not we shall have eternal life?

It would disturb us if we would think about it, for here are our Lord's own words: "*I* was hungry and you gave Me to eat. *I* was a stranger, and you took me in. *I* was sick and you cared for Me. . . . Come ye blessed of my Father receive the Kingdom prepared for you."

The wounded Christ is passing by, let us not fail to recognize Him.



SCIENCE *brings* HOPE *to* GHANA

Sr. M. Francis, M. D.

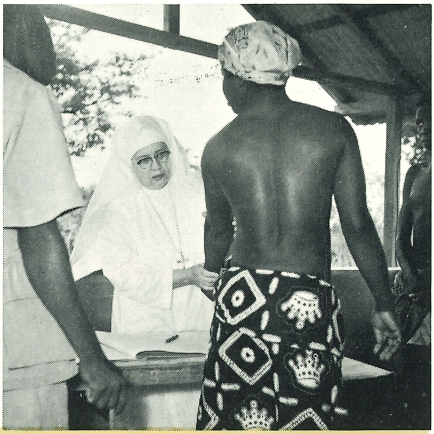
As the year 1960 gets underway, most of us are concerned with the future. There is a feeling of unrest, some apprehension and concern over the months ahead. But whatever comes one thing we are certain of—the New Year will be a year of Change. Some of these changes will be simply a continuation of the changes which have taken place in the past while others will come as a surprise.

The changes which may be forecast in that small sector of human thought and activity covered by the fearsome word "LEPROSY" belong to the first category. It is the belief of all concerned that the future will see events in this field as startling in their way as those in the realm of the atom or the vast reaches of outer space.

Since we can hope for a continuation of past changes, it is good to stop a minute and think of what has been accomplished.

"Leprosy" an ancient word carrying with it the horror and revulsion of centuries has been gradually robbed of some of its terror. Not that we underestimate the enemy, but rather that our day has managed to discover chinks in what seemed like impenetrable armor.

The plight of individuals stricken



Sr. M. Francis, M.D. checks for leprosy spots.

Sister M. Patricia, R.N. dresses Yaw's hand.

with leprosy has called forth compassion in all ages. The lives of the saints of the medieval times abound in stories of their charity to these outcasts e.g., St. Francis visiting the lepers of Assisi, St. Elizabeth of Hungary caring for those of Thuringia. Hardly a saint is found who did not care for these poor unfortunates. But alas, compassion and sympathy were usually all that could be given. Occasionally, as in the Gospel stories, a miracle was worked, but this was the exception. A man with leprosy was a thing apart and the liturgy of the church had a special ceremonial in which the man with leprosy was declared dead to his fellow men. No wonder, then, that to be stricken with this affliction was considered the ultimate in misfortune!

So time went on, and little was changed in the lives of those who contracted leprosy. The disease spread over Europe and then declined. Missionaries to Africa, India, China and all parts of Asia became familiar with it and in the spirit of Christ-like compassion opened places of refuge for its sufferers, for, in most places of the world those with leprosy became outcasts and beggars.

Leprosy patients lined up in village awaiting medicine.

For instance, here in Ashanti a leper could not be chief nor could the chief have in his house one who was a leper.* Until 1949 all that anyone could offer the person with leprosy was sympathy and compassion. Hope of cure seemed as far away as the moon. Now in our day, we have seen the far side of the moon and we have seen HOPE given to those with leprosy.

We have heard much of the Miracle drugs and each month almost finds another remarkable drug to bring health. In 1949, the first—yes the *first,* for now there are a number—of the drugs to combat leprosy was used.

In 1950, the Ghana Leprosy Service was organized. Its aim is a staggering one—to eradicate leprosy from the country. There are at least 45,000 known victims of the disease. A small leprosarium was begun at Ankaful on the coast and the beginnings of a network of clinics to cover the country were made. Each year has seen growth in both departments of the work. The one leprosarium has grown to five, the large clinics scattered over the land have given way to eleven UNESCO land-rovers which give treatment to the patients in their own villages as each week they make their circuit plus a half dozen or so men on motorcycle, bicycle or boat. I myself visit 4,000 patients in the villages. In the past decade hundreds of patients have received discharge certificates certifying the arrest and apparent recovery from the disease. Re-examination of discharged patients is carried out and it is very seldom that a recurrence is found. Although many never report again, it is very probable that they remain well since those who have a recurrence come again for treatment.

At first, the patients were those in villages along the main roads but year by year these are fewer and now the majority are in the bush villages reached with difficulty over roads scarcely deserving of the name.

The mobile units are much appreciated. I remember one man, a laborer working on one of the roads. As the land-rover pulled up along-side he ran over and beamed broadly. After swallowing his medicine, he made a little speech telling me how much better he was and saying how grateful he was to us because now he would not lose his fingers and toes and become crippled as people used to do. It is true that there are still too many who become crippled but the earlier the treatment is begun the less likelihood of this.

The antibiotics which have been such a boom in other fields of medicine have played a wonderful part in controlling the infections which resulted in so many deformities. Christmas Eve a year ago, Yaw Barimah and his wife arrived at Kokofu. Both had the non-contagious form of leprosy and normally would have been referred to a village clinic. However, Yaw was acutely sick. His right arm was one big abscess from the hand to five inches *above* the elbow. For weeks it drained basins of pus. The bones of the thumb were exposed. In the old days, he would probably have died or at the least lost his lower arm. He went home after four months with only a stiff wrist and the loss of his thumb—thanks to antibiotics.

Then there is Abu Wangara. He had

**In Nigeria, the man with leprosy was expelled from his village. Even in some parts of the world he was killed.*

a hard time coming, on the lorry because none of the drivers wanted to take him. The stench of his right foot was overpowering. He lost several toes but today is walking about and unless you notice his foot closely the deformity is not striking. In the old days, the heartaches of such conditions were common. And the ones who cared for the poor patients have been justly honored for their devotion and selflessness. Penicillin and all the line of sulfas and the mycins have done away with that form of heroism. We are grateful for the miracle drugs that save lives and limbs.

The one medicine specific for leprosy, DDS, is made available free of charge by UNESCO. This basic drug is cheap and effective. After some months on it one can hardly recognize the patients who come, as having had the disease. But there are some who cannot take the DDS as we call the diamino-diphenyl-sulphone. For these there are other drugs equally effective though more expensive. At Kokofu we are using four different anti-leprosy medicines.

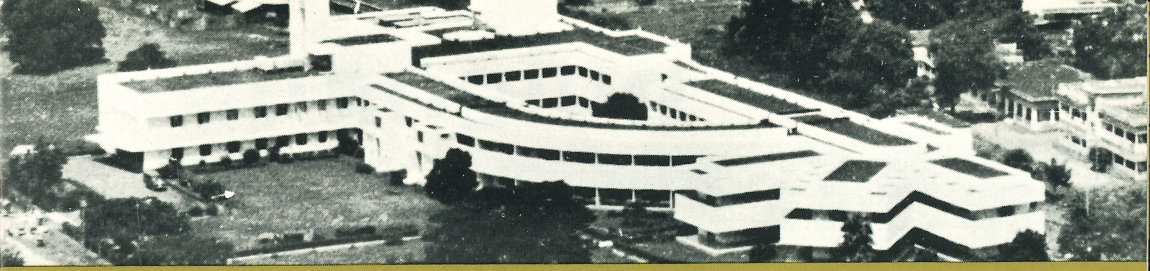
The famous cortisone drugs also contribute to our fight against leprosy. Certain patients develop reactions which are most difficult to control. Two little boys are still on earth and getting well because of these beneficial drugs. One old man came with early facial nerve involvement which showed steady progression until he was put on a cortisone derivative. The pain in his eyes and head had been excruciating and he hadn't slept for a long time. Now he is out of bed and sits in the sun. We hope we have saved him from the facial paralysis, the drooping mouth and sagging lower eyelid which marked so many with leprosy in the past.

The past ten years have also seen the rise of a new concept of the institution known as the "Leprosarium." Formerly a place for cripples and incurables, it was a depressing place. Patients cured of the disease by the spontaneous reactions of their own bodies but hopelessly crippled for life, stayed there. Patients with active disease were isolated but no treatment was available.

The present emphasis is on treatment and the institution is considered to be, not a home for crippled, but a treatment and rehabilitation center to which patients come and from which patients *leave* to *return* to normal life in their communities. In the near future, plastic surgery to replace paralyzed muscles by others, a technique developed for polio, war or accident-victims, will be possible for the patients who develop claw hands or foot drop. In the old days, such surgery would have been useless because the course of the disease could not be halted. Modern therapy makes such surgery very helpful and we are hoping to see it started here in Ghana in the near future.

Besides the use of corrective and plastic surgery which now offer relief from unavoidable disabilities which have been suffered by certain patients, the field of prosthetics which substitutes artificial limbs and appliances for those no longer functional is one which is most promising.

As research workers continue their studies of all the phases of leprosy a better understanding of the disease is certain to emerge and with it a better means of treatment than we have at present. The past ten years have seen a rosy dawn but only the dawn of what we hope will be a most beautiful day.



Holy Family Hospital, Dacca, East Pakistan.

between the Gol-Mohur trees

Sister M. Daniel, S. C. M. M.

A few years ago, as the two ends of a freshly cut red ribbon fluttered to the floor, Holy Family Hospital in Dacca, East Pakistan, was declared officially open to receive patients. About a thousand of Dacca's citizens were present for the ceremony. They and their fellow citizens had watched with interest the construction of the great, spreading, concrete arms of this center for healing. Naturally, they wondered what kind of a heart it would have.

During my stay in Dacca, I had the opportunity of feeling the pulse of this wonderment. Each trip between the brilliant red Gol-Mohur trees en route to the bazaar was a new experience for me as well as an opportunity for the cheerful, gracious Bengalis to ask their questions about the new hospital. I discovered the reason for their curiosity as well. It seemed that behind each sari-draped shop and Moghul arch lay someone held prisoner by dysentery or a fever, or a mother afraid that the child she was bearing would die as had the others before it, or just as frequently, another in need of an operation.

The questions began even at my first stop—the Foreigners' Registration Office. The colorful cycle rickshaw brought me to the gate of historic Fort Lal Bagh. It was like stepping into the pages of history of Dacca's glorious past. In the midst of interesting examples of Moghul architecture, stands the Registration Office in its utter simplicity. After accepting the gracious invitation to be seated, I could not help noticing the bright, sun-lighted vista of today's green grass clinging to the stones of yesterday's glory. It was a real "picture" window without the interference of a pane of glass. The representative of the Government of East Pakistan in rich, soft tones made the necessary official inquiries. Deftly he placed his rubber stamp on my forms and immediately dispatched a peon with them to get the required official signature. As we waited, the officer relaxed somewhat and forth came the question, "Is Holy Family Hospital only for women and children?"

"No, we have a Male Patients' Department, too. However, 75% of the beds are reserved for women and children, because there seems to be a special need for medical facilities for them."

The next question revealed the Officer's deep-rooted adherence to the Islamic faith: "But, then, is *purdah* really respected there?"

"Yes, the female wards are in a separate section of the hospital. And of course, if the lady occupies a private room, there is no problem at all."

Our conversation was interrupted by the return of my papers, and soon I was accepting the offer of a color-shirted rickshaw-wallah to take me on my way.

A few days later, I found myself on the opposite side of the desk from this officer. It was Visiting Hour at Holy Family Hospital, and he smiled a greeting as he passed the Admission Desk where I happened to be on duty. As he stopped, I inquired, "Do you know someone here?"

"Yes, my daughter has been admitted for her fever, and Doctor says she is doing well."

Another day found me passing under the porticoes of the State Bank of Pakistan. I had to go to the Treasurer's Office to inquire about the proper procedure in paying a tax due from the hospital. After explaining the process, the kindly gentleman paused to think for a moment. Then, "Is it very expensive to come to Holy Family Hospital? For instance, how much would it cost for a mother to have her baby there?"

I enumerated the very reasonable fees charged for such a case in the wards, as well as the higher ones required for a private room. Then I inquired, "Is it her first child?"

"Yes, it is my young niece, and we want so much for everything to go all right."

"Then you should not wait until the time of delivery to bring her. The doctor can do much more to help if your niece comes for antenatal care regularly."

"Really, when should she come . . .?"

Not many days later, I was again at the Admission Desk when a handsome young man approached. "I believe you are the one to whom my wife's uncle spoke at the State Bank recently?"

"Oh yes, she is going to have her first child, isn't she?"

"Yes, can you tell me where I should bring her and when?"

I had explained all this in the bank office, and the uncle had judiciously made notes. However, I could understand the husband's wish to see for himself before entrusting his wife to the strange Sisters at the new hospital.

A few weeks later, duty called me to the southern tip of the subcontinent. As I left, the policeman at the airport thumbed through my passport and placed his rubber stamp on my visa. Then he looked up and said, "Is there any regulation at Holy Family Hospital about which religion the patients hold?"

"No," was my reply, "They only have to be sick. Anyone who is ill may come."

Of all the questions asked about the hospital from among the cloth bazaars, the brass bazaars, the various offices and all the busy by-ways of Dacca, it seems to me the most important was this asked as I crossed the threshold to leave East Pakistan. The answer to this one is the reason for all the years of study and preparation behind each Sister on the staff at Holy Family Hospital—that all who come, whether patients or visitors, find within the concrete arms of that building a warm, universal love of man for fellow-man in the Name of the Creator—a love that will in turn be expressed through the medium of Pakistani hearts and hands.

changing

therapy

Sr. M. Frederic, M. D.

"If only people could understand that TB is so much more of a problem than leprosy." The speaker was Bishop Westermann, S.V.D., from a neighboring diocese in Orissa, India. He had come to show our hospital to some of his friends including an S.V.D. missiologist, and echoed our thoughts as we passed the men's TB ward.

A whole succession of names flitted through my mind — Joseph, whose empyema we drained over a year ago, hardly daring to dream that his x-ray today could look as clear as it does. Now he has a full time job — sure of two square meals a day — Ram Das, an excellent Hindi pundit, sorely missed by the school staff during four months of therapy here, returned to his former job — Narayan, whose disease followed its relentless course to death with severe hemoptysis (hemorrhage from the lungs) — Coleen, a beautiful young Anglo-Indian girl from Calcutta whose parents died of TB, almost ready to return to school— Rambrit who signed out because it took too long to be cured! — John, brought in to die by his father, a coolie who had nothing, and his parish priest, who also had nothing to offer. For weeks he remained semi-comotose from the toxicity of his illness, yet tomorrow he will go back to school — Radhika, admitted only yesterday with her two year old daughter, both coughing violently, with fever challenging the tip of the thermometer. — Jayanti, sole support of her two children with bone TB, who will soon return to her job of lace making. It is easy to remember the occupants of our 18 TB beds, their hopes, their fears.

Just now in the middle of writing this I was called out to check a young Sister who has finished a year of therapy, back for months already in her mission school. Sometimes it is a priest or aspirant for the priesthood. TB is one of the greatest occupational hazards in the life of a missionary here.

TB actually constitutes a very serious problem for the whole nation with two and a half million cases and 500,000 deaths annually. In its Five Year Plans India laid great stress, and rightly so, on the preventive aspects of the disease. During the last few years 28 million persons have received BCG vaccine.

In spite of the fact that all sorts of methods and drugs had been tried, no effective treatment was really available for TB patients until the discovery of streptomycin in 1944; this was followed by INH and PAS. These and their combinations have proved effective in the majority of cases. Improved surgical procedures combined with the drugs have completely changed the outlook of the patient. Thus there has been a revolution in the treatment of the disease and the need for prolonged bed rest is now becoming less and less.

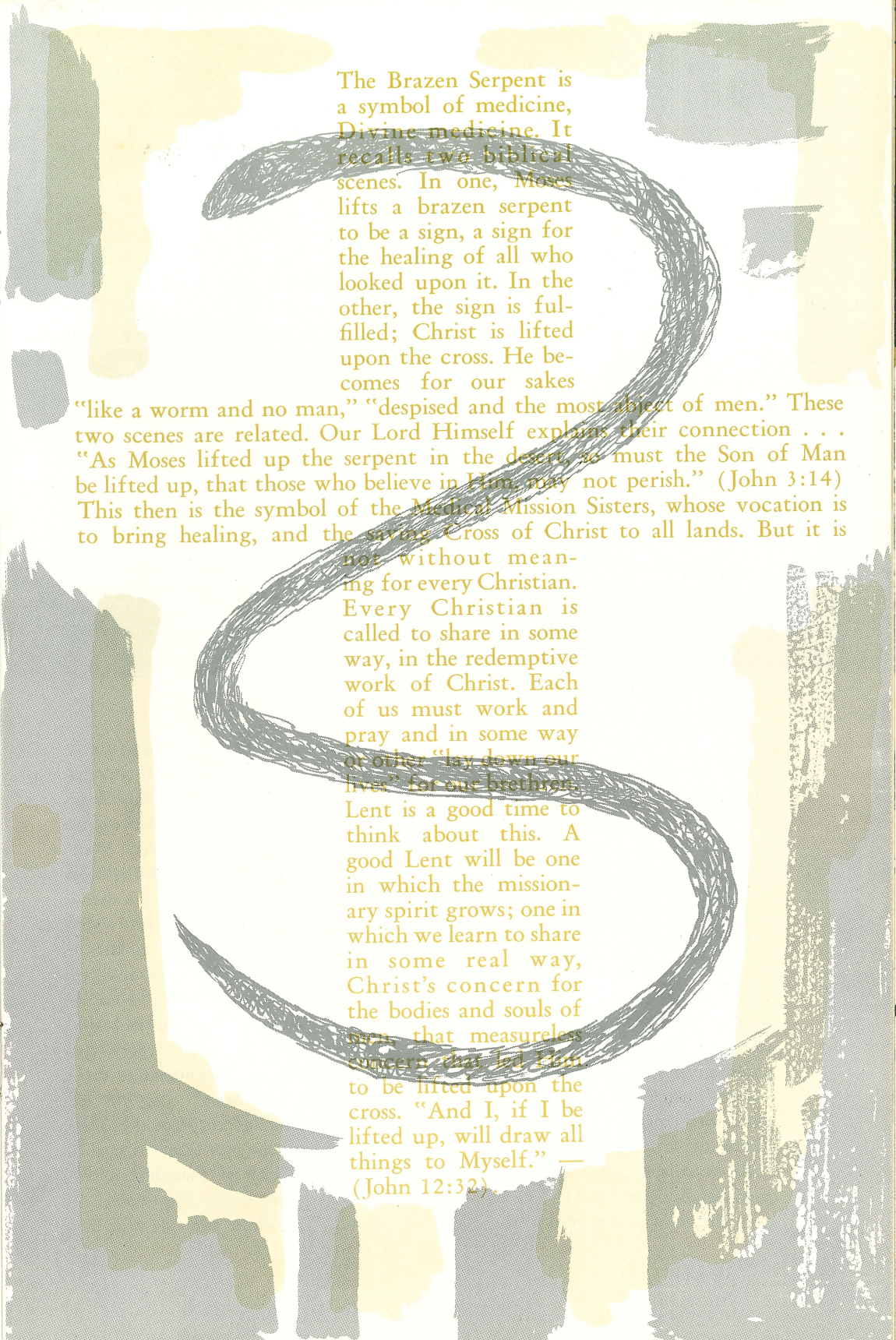
In the old days it used to trouble me that we did not have a separate unit for TB patients, instead of a separate ward in the general ward block. Now with the increasing emphasis in the medical literature on the treatment of TB patients in general hospitals, we are simply a part of a modern trend, more evident since the closing of the famous Trudeau Sanatorium. This is probably a landmark in the history of the treatment of TB in the West.

Last October, at the Catholic Hospital Association Convention in Bombay, Dr. Billimeria, a young chest surgeon from Panchmani Sanatorium, gave an excellent talk on TB surgery. In the question period afterwards, he not only approved the policy of a TB ward in the general ward blocks here in India, but, considering the *magnitude of the problem,* said that he thought it allowable to accept patients into the general wards, with due safeguards of course. This is indeed a radical approach but understandable in view of the great shortage of beds for TB patients.

How great is the problem can be judged by the fact that patients come with the disease advanced enough to be readily detected with the stethescope, and surely guessed without it. A positive smear on direct examination of the sputum is commonplace. How many more we would pick up with routine chest x-rays it is hazardous to guess.

Even when we send the patients home with a negative x-ray, we wonder how long it will remain so. Domiciliary care, the ideal today, is very difficult to practice in India. In Jamshedpur it is being worked out slowly by the Mercy Sisters under the auspices of Tata Steel. Even there, under more or less ideal conditions, progress is often defeated by ignorance. The return to overcrowded living quarters, insufficient diet, and heavy work, plus further exposure to open TB, often spells relapse. Except in the patients who come from mission stations, both Catholic and Protestant, or from certain institutions like the Catholic press or college, where there is someone interested enough to see that therapy is continued at home, there is very little follow-up of patients. Months later, the patient may come back negative, or he may come with a frustrating relapse.

TB is one of the greatest obstacles to India's progress, and it is one of the very real handicaps to the missions in this area. Its incidence among college students alone reflects the problem it is to both nation and church. These are the young men and women who should be the future leaders of India. One of the main points I like to make to the social service students who take the public health course is, that, if in this alone, they would be auxiliaries to the existing medical personnel, these young social workers would perform a remarkable service to their country.



The Brazen Serpent is a symbol of medicine, Divine medicine. It recalls two biblical scenes. In one, Moses lifts a brazen serpent to be a sign, a sign for the healing of all who looked upon it. In the other, the sign is fulfilled; Christ is lifted upon the cross. He becomes for our sakes "like a worm and no man," "despised and the most abject of men." These two scenes are related. Our Lord Himself explains their connection . . . "As Moses lifted up the serpent in the desert, so must the Son of Man be lifted up, that those who believe in Him may not perish." (John 3:14) This then is the symbol of the Medical Mission Sisters, whose vocation is to bring healing, and the saving Cross of Christ to all lands. But it is not without meaning for every Christian. Every Christian is called to share in some way, in the redemptive work of Christ. Each of us must work and pray and in some way or other "lay down our lives" for our brethren. Lent is a good time to think about this. A good Lent will be one in which the missionary spirit grows; one in which we learn to share in some real way, Christ's concern for the bodies and souls of men, that measureless concern that led Him to be lifted upon the cross. "And I, if I be lifted up, will draw all things to Myself." — (John 12:32).

Ten years ago 'new' Holy Family Hospital, Rawalpindi, was a big, half-empty building out in the middle of nowhere. Buffaloes grazed around it. Muddy roads led to the Leh River behind where the dhobies pounded dirty linen and naked little boys herded their goats. The city bus made its way out to the hospital only occasionally in a day and *tongawallas* collected a pretty fare for a horsedrawn ride. When the Sisters started the new building so far out of town . . . and five miles is a long way on foot or in a horse-drawn carriage . . . everyone said, "Why do you want to go so far away? You'll never have any patients in that spot."

For awhile it really looked as if the pessimists were right. The building was opened just after Partition, the separation of Pakistan from India, with its consequent disturbances and troubles. Most of the patients of 'old' Holy Family were Sikhs and Hindus, whose women came to the hospital quite freely. When *they* left, it took time before the Muslim women began to occupy the vacant beds. The out-patient department wasn't a problem; they came there in droves, not only from "Pindi" but from all the villages around, but very few would be admitted. They had always had their babies at home and as for surgery, that was as bad as a death sentence to them. When they found out that we had women doctors and they could operate, a few were willing to take the chance. But times do change, though it is hard to see the grass grow. The women of Pakistan have seen and grasped their

IS A LONG TIME

Sr. M. Elise, M.D.

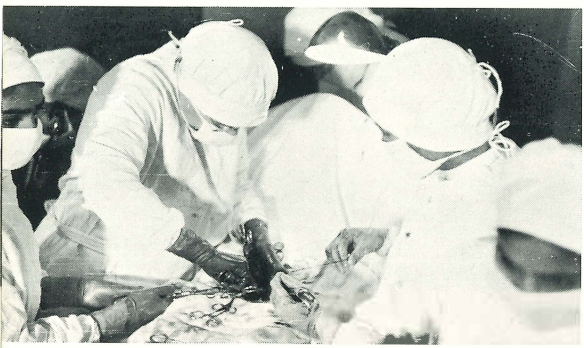
opportunities, better and quicker than anyone would have predicted in 1947.

Here are some figures to illustrate the point: in 1946, the year before the Partition of India and Pakistan, old Holy Family Hospital had 1053 deliveries, of which only 224 were Muslim babies. In 1959 there were over a thousand deliveries and of these 900 were Muslims. The change has been gradual but unmistakable. The purdah ladies now no longer hesitate to come, even those who have had eight or ten babies at home. "It is so nice to lie in bed and have your baby brought to you, clean and tidy," said one of them! The first sound a Muslim baby is supposed to hear is a phrase from the Koran. But the head-shaving ceremony still has to be done at home, so by the sixth day after the baby's birth the mother is anxious to be on the move. If there are no contra-indications, we usually give in with good grace, although the majority of these women are terribly anemic (sometimes they come in with less than 10% hemoglobin!) and could well stand a longer rest.

An even better indication of the change in the attitude of women is the enrollment in the Nurses' Training School. Up to 1947 we had never even had an application from a Muslim girl, not to mention a student or graduate. At the time of Partition the Pakistan Army officials made a concerted drive for nurses and they asked Holy Family Hospital to take a group in training. That started the ball rolling and since then we have always had Muslim girls

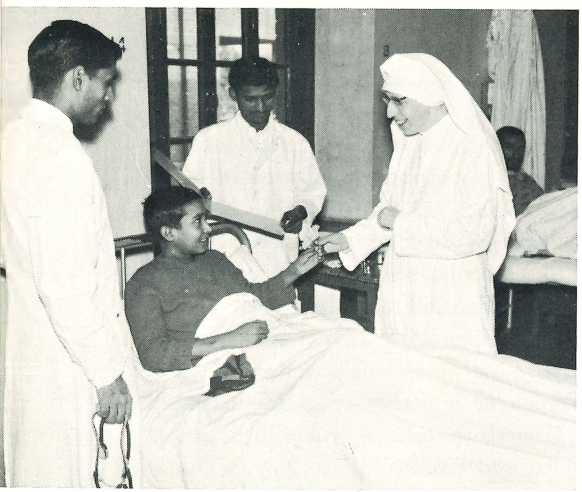
in each new group. This year we have up to 50%, the best we have ever done. It is still not in the proper proportion to the population but a great step forword nevertheless.

Ten years of progress in medicine have brought many changes to Holy Family. Gone are the days when the annual typhoid scare threw the entire hospital into frantic and often unavailing activity. Now most typhoid patients are out of danger before they even know what they had. The new drugs have done wonders in this country where infectious diseases still make up a large part of the doctor's work. Not only typhoid, but also the dysenteries and the enteritis of childhood have largely lost their sting. Only last week a little American girl was admitted with 106° F. temperature and convulsions due to dysentery. Ten years ago her chances would have been slim. Twenty years ago they were practically nil. This week she walked out after five days, in fine fettle. The antibiotics have made all the difference. A row of little graves in the Murree cemetery, all marked "beloved son or daughter of so-and-so, aged two years" shows clearly the effects of the country, on the babies of the West, fifty years ago. Deaths from simple dysentery are really rare nowadays and invariably due to delay in treatment.



Sister M. Elise, M.D. operating. Holy Family Hospital, Rawalpindi, W. Pakistan.

Grateful patient. Sister M. Elise, M.D. and Dr. Alam (left) make rounds.



Ten years of steady efforts in educating the public have started to bear fruit at last. Permission for an operation comes much more easily now than formerly, and not rarely, a woman will step up and ask to sign her *own* permission: an unheard of procedure twenty years ago. Children are being admitted without their mothers with them. Pediatrics is a much happier place, with the convalescent and mildly ill kiddies all playing and eating together, instead of clinging to their mothers like limpets.

One of the most spectacular improvements has been in the matter of blood transfusions. That used to be a major operation—to get a man to give blood for his wife. Ten years ago there were no more than three or four transfusions a year, and those nearly all on Europeans. But when major surgery became more numerous, the need for blood made

itself felt. At a certain point we simply made up our minds: either we get the blood for the patient or there will be no operation. It worked. Not without a battle or rather a thousand battles, but in the end the people themselves began to see the difference. It is surprising and gratifying how often the patient comes back after a week with one or more donors!

We still have not succeeded in building up a good blood bank. To give blood for a wife or sister who needs an operation or is having a baby, that is one thing. To give blood merely as a good deed is entirely different. Most Punjabis, big, burly men with 100% hemoglobin (quite the opposite of the women), still consider themselves "too weak" to give a pint of blood. But a start has been made and with continued effort the rest will follow.

Anyone who knew this hospital ten years ago and visited it again for the first time now, would get an agreeable surprise. The surroundings have changed considerably. The city has followed us out and a pleasant "Satellite Town," as the suburbs are called in this country, has grown up around us. Now that the capital city of Pakistan will be transferred ten miles outside of 'Pindi,' on *our* side of town, we will no longer be the "country cousins" to our Karachi sisters. The hospital itself has improved and developed steadily. The gardens and fields are green and colorful in the right seasons and the cement road from the gate to the entrance is a joy to have, after so many years of broken bricks and mud puddles.

Even the patients remark about the differences. One evening we showed USIS health movies in one of the women's wards. Said Sugra, a real old-timer here, "This is the nicest hospital in Pakistan. Patients even get to see movies while they are getting well." Little things like that build up good will and gratitude, which returns to us in the form of *more* patients, *more* work, and *more* satisfaction! As the work grows, so does the staff, from thirteen sisters, five doctors, and 26 student nurses in 1947, to 21 sisters, eight doctors and 65 students at the end of 1959. In that time the daily average of hospital in-patients jumped from 77 to 185, though the average stay remained the same, about eleven days. Quick turn-over is the rule here. The total number of transfusions in 1958, by the way, was 1,558. Percentage-wise, this is quite a feat!

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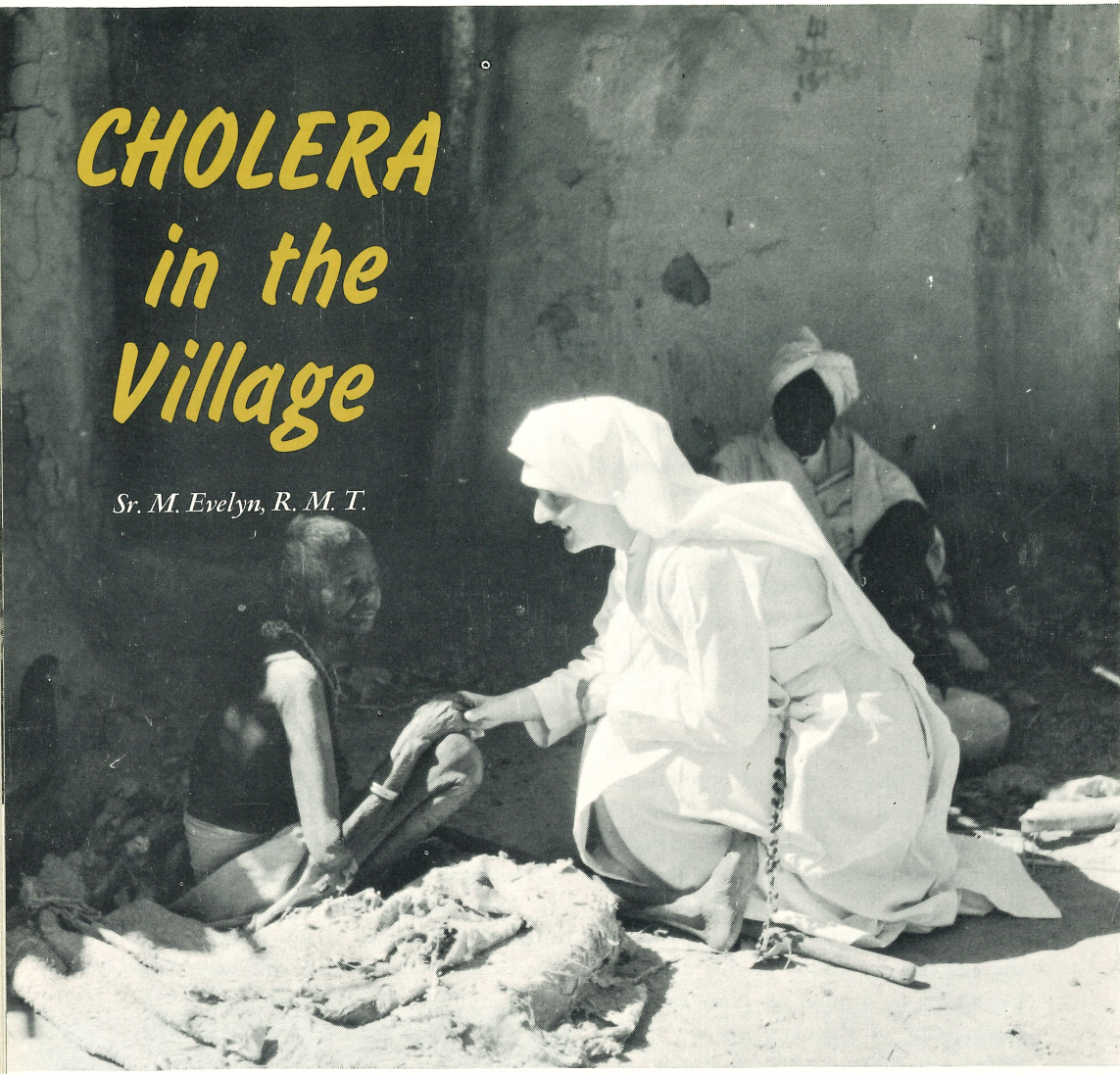
CHOLERA in the Village

Sr. M. Evelyn, R. M. T.



Sister M. David, R.N. greets a poor blind woman on the way to the village in Mandar.

One Monday late in the morning, Sr. M. David saw a group of Ouraon men standing outside the Women's Ward, Holy Family Hospital, Mandar, India. The group was silent and Sister, knowing her villagers, knew that there was something on their minds. It seems to be part of their etiquette to wait for those they respect and esteem to begin the conversation.

They would still be standing there if Sr. M. David had not asked, "Do you want something?" In an instant the group came to life. Would Sister please come to their village? There is a very sick girl—"she is my daughter" someone interrupted, too sick to come to the hospital. After questioning them further, Sr. M. David went to find Sr. M. Barbara, M.D. to tell her the story. Doctor said, "It sounds like cholera. Pack an I.V. set. Take glucose and saline and some coramine for good measure."

An army knapsack was packed and Sister David and I set out on cycles with one of the men showing us the way. Our guide ran along side us the whole way, about two and a half miles. It was about one o'clock with the tropical sun overhead, the journey over the dry rice fields seemed very long. When we arrived, we found the patient lying on a mat on the mud floor. She was bathed in cold perspiration, her pulse very weak and she was extremely restless. After our eyes had become accustomed to the dark, we noticed that about 30 relatives were huddled into that one small room. Only the doorway admitted any light. The house itself was cool.

One look at the girl and Sister David's experienced eye told her that she was in a serious condition. Sister quickly went to work. First the coramine, next the I.V. In one corner of the room was a coil of thick rope. Sister instructed the men to bring the coil closer to the patient. She turned over a *tokri*—a home-made basket similar to our bushel baskets but only half as deep. Sister unwrapped her sterile can with sterile saline and added the glucose from sterile ampoules, covered the can with a sterile towel and placed it on top of the over-turned basket. Since the girl was lying on the floor, four feet was high enough for the I.V. Now the vein, some adhesive tape to hold the needle in place, adjust the flow of the saline—sit down and wait. Sister David was courteously offered a block of wood—one foot square and two inches high—to sit on. I stayed in the background ready to help when needed. For a short time, the girl seemed to relax but it wasn't long before her nausea returned. The place for her was in a hospital. Sister David knew she must ask her father, not her husband, (according to their customs) if he would permit her to go to the hospital. It was the girl's only chance, otherwise she would be dead within 24 hours.

Then in subdued tones the family council began. Drip, drip, drip went the I.V. Sister gave another coramine injection. Every now and then the father would question Sister. Couldn't she recover just as well at home as at the hospital? What other medicine would be necessary for her? About how many days would she have to remain in the hospital for she had an infant, and who would feed it? etc., etc. Just as the I.V. finished, the head of the family (the father) announced that they *would* take her to the hospital. It had taken them three hours to give their consent. She was placed on a string bed to which poles were tied. Over the pole was draped a sari to protect her from the sun, wind, and dust. Two men carried her and our village ambulance arrived at sunset. She was put to bed immediately, examined by Sister Barbara, M.D. and more intravenous fluids were begun.

When Sister M. David went to see her the next morning she found the girl, much to her surprise, sitting on the edge of the bed, drinking strong tea that had been brought her from home. Her first words to Sister were "When can I go home?" As serious as had been her condition the day before, just as dramatic was her recovery. After a few days more in the hospital, she was discharged. She would be the belle of the village for she had been to the modern hospital and would be able to tell a spellbound audience of all her "adventures."

R.I.P.

FATHER MATHIS — CO

For some time we had been informed of the illness and growing weakness of Rev. Michael A. Mathis, C.S.C. So, the news of his death was not a surprise. Nevertheless it produced deep emotion due to the many memories suddenly brought into focus. It was not sorrow, for Father died full of years and good works, but a sense of loss and separation from one who had been so intimately connected with our very existence. It was Father Mathis whom God's Providence gave us to help to bring our Society into being. He had the necessary qualities for the task. He was an ardent lover of the missions, which made him participate in the general mission endeavors in the United States and launch out into new mission enterprises in his own Congregation of Holy Cross. For many years he put his intellectual gifts, his qualities of leadership, his resourcefulness and his vigorous and cheerful personality into the service of the missions.

This interest in missions brought him also face to face with the appalling suffering in mission lands where people not only are victims of many more diseases but are for the most part deprived of effective relief due to the lack of medical care. During a Visitation to the missions of his Congregation in India, Father Mathis was asked to find nurses for the government hospital in Akyab, West Burma. Upon his return Father found and sent out four nurses, but due to the lack of proper social conditions they could not stay. According to Father's statement the situation practically imposed a community life upon them, for which they were unprepared. Father was also delegated by the newly founded Medical Mission Board in New York to investigate medical mission activities and needs in India. This brought him into correspondence with me as I was then the doctor in charge of St. Catherine's Hospital in Rawalpindi in North India.

When I went to the United States in the interest of Medical Missions about a year later, I met Father Mathis in Washington, D.C. Just about that time the four nurses he had sent returned and Father asked me what I thought would make it possible for professional young women to devote themselves to the care of the sick in the missions. As this problem had occupied my mind, I was ready for the question.

It was Father Mathis' experience that made him interested in a religious community of Medical Mission Sisters. Once convinced of the value of medical missions, he put his whole heart and soul into it and did what he could to help us to get on our feet. He obtained for us spiritual care and religious instruction from the Holy Cross Fathers and gave us much of his precious time. We were all inexperienced in religious and community life and strangers in Washington. Through Father's kindness, his friends often helped and advised us. His cheerful personality itself was a stimulus and his understanding of material needs often surprised us.

From 1933 to 1938 Father Mathis devoted himself entirely to our Society. He lived in a little house on our grounds in true mission style. During these years

Reverend Michael A. Mathis, C.S.C. "Few have loved the Church so ardently as this little man of God. Few have done so much in a short time to bring others to love the Church. Since 1936, his interest in the Church's liturgy has been so intense that he now has a sure place in the history of the Church in this country." (Religious Bulletin, Notre Dame)

especially, he instilled in us a love for the liturgy and even meditated with us on the Mass of the day. He also introduced us to the practical side of promotional work. He spent long hours making a film, *The Good Samaritan*. It was an innovation in mission films as it was the first one with sound. Father made himself a beggar for us and preached for us at Church Collections.

In 1938 Father Mathis was assigned the duty of Chaplain at St. Joseph's Hospital, South Bend, Indiana—his home town. He must have been a great help and comfort to the sick and dying with his easy approach.

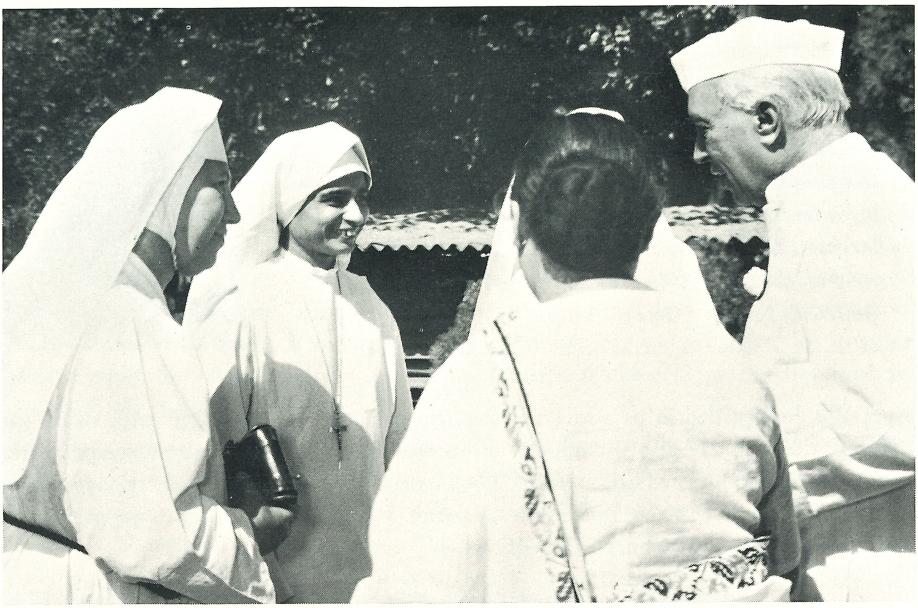
In 1947 Father began the Notre Dame University Summer School of Liturgy program, which absorbed the last years of his life to the benefit of many, including our Sisters. Through his academic training, his knowledge of languages and widespread interest, he was familiar far and wide with men, books and movements in this field so that through the generosity of his friends he could invite eminent professors to teach the summer courses. He himself was not only the Director of the school but the embodiment of its spirit. Father was simple, totally like Nathaniel—without guile. Perhaps that was what made him so beloved. He was unique and "unique" was his favorite word. He was always ready to render service and that is why, perhaps, he could enlist the help of others so easily. His spirit could not be dampened by criticism, and his bouyancy was extraordinary. As he got older and older, his spirituality shone out more and more, and it made one happy to see that everything he did had the blessing of God on it in spite of difficulties and trials.

In spite of his 75 years, Father's one desire was to do more. He sent us his summer program for 1960 looking forward to directing it again. Instead, God called him to his reward, which must be great. The cable told us that he died peacefully at 2:30 p.m., March 10th at Notre Dame.

Our gratitude to him is great but inadequate for all that he has done for us. It is a consolation to know that God Who knows everything will be his reward exceedingly great.

NEWS FROM

INDIA **We Visit Nehru**



New Delhi. (L. to R.) Ursuline Sister from Ranchi, Sr. M. Francis Pauline (Yadava), Indian Medical Mission Sister, Indira Gandhi, and Nehru, Prime Minister.

Recently I went with two Ursuline Sisters from Ranchi, who were celebrating their golden jubilee, on a visit to the Prime Minister.

Guards ceremoniously stopped us at the gate. After the customary showing of passes, and signing of books, we were ushered in with a group of medical students from Poona.

The master of ceremonies had us seated in a few minutes, and we were delighted to find ourselves quite near the Prime Minister. He came in so quietly that he was almost at the microphone before the students could get in their welcome cries. He pleaded with the students to stay true to their role of students and good citizens. After that he came over to talk to us. I was surprised to find him greyer, more tired, but kinder than the newspaper photographs depict him. In the excitement of greeting the Prime Minister, I forgot all I had planned to say. *Pandit Ji* must have noticed my predicament because he soon had me answering questions about my family, my work, and about Holy Family Hospital.

When the reception was over, the first lady gave the three of us a snack in one of the guest rooms. Over coffee we learned that Mr. Nehru works from early morning till after midnight, and is also a vegetarian. It was a privilege to hear about the simple tastes and home life of this man who guards the future of this young nation, so strategically placed.

Sr. M. Francis Pauline, R.N., *Holy Family Hospital, New Delhi, India*

OUR HOUSES

INDIA The Perils of Sister Pascal

Several of us had to attend a nurses' meeting so could not witness the presentation of the new ambulance. We came home expecting to see the ambulance on display, but were told that Sister M. Pius had driven some of the nurses to the river for the maiden voyage. Well, we ate supper, said Compline, and still the maiden had not returned from her ten minute voyage! As we were on our way to bed a group of haggard faces told the story of no gas and the great push home.

Several days later, Sister M. Pius received a call from the Archbishop requesting the ambulance to come and pick up a sick priest. Sister asked me to drive into town and bring him back. Sister Francis Xavier, who is graduating from medical school this year, acted as medical adviser and co-pilot.

With the roar of our four cylinder motor, we were off in a cloud of dust and the cool evening temperature of 106°. As we entered the Cathedral grounds, a group of priests came out to gaze upon our little Fiat ambulance. With much to do Father was able to squeeze his big six-foot-two-inch frame onto our little stretcher, in the back, and we were off. The Archbishop and four other priests were on the verandah as we left on this errand of mercy.

We were off, all right, but only for two hops and a skip, when the motor died very unceremoniously at the Bishop's feet. The reverend clergy came to the rescue and pushed us around the compound until the engine caught up again. Once more we were off.

The car ran asthmatically for about ten minutes and then gave up the ghost. This time pushing would not help. We tried every trick we knew to start the car, but to no avail. Sr. Francis Xavier climbed down from the cab and started her hike for the nearest telephone. In the meanwhile, the gay thought came to me, perhaps the gas line is plugged, I will blow it out. Eagerly, I unscrewed the gas cap and huffed and puffed into the tank. As I withdrew my dainty little mouth from the hole—whoosh—the added air pressure forced the gas out of the hole up into my mouth and face. Father must have thought that I was having a heat stroke or epileptic fit for all he could hear was my sputtering and weird sounds due to the throat soothing effects of a gasoline cocktail.

Without further ado I set out for the little police traffic hut a block or so away. When I arrived at the light switch hut, the policeman took a look at me and jumped off his stool to see what this strange thing was. My eyes were swollen and tears were pouring out from the gasoline burn, and he showed all the manly concern over a woman in distress. I explained my story as best my Hindi would allow, and he came to the rescue by turning all four traffic lights red and dashing out to catch me a taxi.

He told the driver to hurry the patient to Holy Family Hospital, but did not tell him that the patient was several blocks away. I jumped into the cab to show him the way to the ambulance, but he took one look at me and shouted that he would take me to the hospital quickly. I told him that *I* was

not sick, but the patient was that-a-way! Never daunted, he insisted that *I* be taken to the hospital. Finally I told him that I would jump out of the car if he did not go the way I told him. At last we reached the ambulance and with the taxi driver still shaking his head in dismay, transferred the patient priest to the taxi.

After another half hour Sr. Francis Xavier arrived with the repairmen, and with much tinkering and talking they finally started the motor.

Unfortunately, by the time we reached home, the scars of battle had begun to disappear and all the sympathy we received was, "what took you so long, Father arrived an hour ago?" The moral—*Pride goeth before a stall.*

Sr. M. Pascal, R.N., *Holy Family Hospital, Kodarma, India*

AFRICA Caught in the Act

We are spending our vacation at Kokofu. The grass in Kokofu's front yard looks so very neat now. They have just acquired a power-mower run on petrol, and one of the laborers is being taught the delicate art of keeping the motor running, hanging on while it bucks like a bronco, and of avoiding rocks, small trees and flower patches. When Zasipaya first got the job, he beamed with delight, but as of today his countenance is a bit clouded as he views the new monster with mixed emotions. Formerly he could lie down under the nearest shade tree when Mr. Thornley's back was turned, but today he made the horrible discovery that when he stops working and stops the motor, the boss immediately appears on the scene, and by some diabolical intuition knows that Zasipaya's work has stopped. He has already cut in one afternoon, as much as he does in two weeks by hand, so I suppose the big question in his mind is: What work will I have to do instead for two more weeks? ! !

Sister M. Theodore, B.S.Pharm., Holy Family Hospital, Techiman, Ghana

To Africa
Dr. and Mrs. Joachim Gfoeller and family aboard the S. S. African Glen before they left for W. Africa where the doctor and his wife, a nurse, will serve at Holy Family Hospital, Berekum. Sr. Jude Marie, R.N. of Montclair, N.J., sailed with them, also assigned to Berekum.

PAKISTAN The President of Pakistan at Holy Family Hospital, Rawalpindi

Hon. President Ayub Khan of Pakistan

Sister M. Gemma, R.N. admires new son born to Naseem, the President's daughter, at Holy Family Hospital, Rawalpindi.

Last night we had a rare privilege. President Ayub Khan came to the hospital to visit his daughter who gave birth to a nine pound boy on the afternoon of the 11th. She had two girls already so you can imagine a boy was everyone's very ardent wish. She is married to the son of the Wali of Swat State, who is in line to that title, when his father dies.

About 5:30 the first message came, over the phone, that the President would be coming soon. Then, his personal guide or attendant with policemen, came to look the hospital over and walk the route that the President would be taking. When that was cleared satisfactorily, they left and we waited for the next message. At 6:00 the phone again rang and informed us that the President was now leaving his home. Sisters, nurses, staff quickly gathered and were in the lobby to greet His Excellency and Mrs. Ayub as they entered. The President shook hands with several of the Sisters and thanked Sr. M. Elise, the doctor, for taking such good care of Naseem. He saluted and greeted the rest of the staff and then we took him up to the room where Naseem was waiting for him. He was very friendly and easy to talk to and greeted all as he went down the corridor. Sr. Rosina had the baby all decked out in a lovely pink outfit and she and Sr. Gemma brought the precious package in for the President to see. This is his first and only grandson. He stayed for about 15 minutes with Naseem but Mrs. Ayub remained for a longer visit. As he was leaving the hospital I tried to get a picture with the little box camera we have . . . and no flash. I knew it could hardly turn out and he must have sensed the same thing because he smiled and asked if I'd like his picture. What could I say but, "Yes, your excellency." He immediately designated one of the men to see that we got the picture. I then promised that I would take a nice one of the baby for him and he said that was fair enough. With that, he was at the door and quickly whisked away in a long black car.

SISTER M. PIERRE, *Holy Family Hospital, Rawalpindi, W. Pakistan*

On the feast of Our Lady of Lourdes Medical Mission Sisters throughout the world made vows of obedience, poverty and chastity, consecrating their lives to the service of God, in the person of His sick and poor. Here in Philadelphia, Rev. Thomas Duffy, C.S.C. presided at the Profession ceremony during which six Sisters made final vows and four Sisters made first vows. The Rev. Gerard S. Sloyan of the Catholic University, Washington, D.C., gave the sermon. In it he bade the Sisters who were making vows to show forth the joy of Christ while speeding the day of His coming with the works of the Kingdom—healing the sick.

FINAL VOWS

Sr. M. Aloysius Schneider, R.M.T., St. Louis, Mo. (in Ghana, W. Africa)
Sr. M. Angelina Alfafara, B.S.Pharm., Philippine Is. (in East Pakistan)
Sr. M. Cajetan Major, North Ormesley, England (In West Pakistan)
Sr. M. Celine Bernier, R.N., Providence, R.I. (in West Pakistan)
Sr. M. Cleophas Lasche, Cascade, Iowa.
Sr. M. Cuthbert Hellwig, M.A.Rel.Ed., Liverpool, England
Sr. M. Domitilla Alfafara, B.S.Pharm., Philippine Is. (in West Pakistan)
Sr. M. Fernande Pelletier, M.D., Fort Kent, Maine
Sr. M. Francisco Fernandes, M.D., Poona, India
Sr. M. Godric Coombes, Bournemouth, England (in England)
Sr. M. Grace Peralta, Malta (in India)
Sr. M. Jane Stanchak, R.N., Middlefield, Ohio (in West Pakistan)
Sr. M. Liguori Ansel, R.T.x-ray, Philadelphia, Pa.
Sr. M. Mathias Zimmerman, M.D., Fort Loramie, Ohio
Sr. M. Maura Robinson, R.N., Ontario, Canada (in India)
Sr. M. Norbert Hummel, Jeffersontown, Ky.
Sr. M. Yvonne Lachance, Winnipeg, Canada
Sr. M. Zita Sampon, Milwaukee, Wis. (in Venezuela)

FIRST VOWS: Philadelphia

Sr. M. Caritas Reardon, L.I., N. Y.
Sr. M. Darrah Degnan, Toledo, Ohio
Sr. Imelda Marie DeCoster, Roseland, N. J.
Sr. M. Vincentia Hayes, South Norwalk, Conn.
Sr. M. Lioba Jansen, Emmerich-am-Rhein, Germany (in South Shields, England)
Sr. M. F. Rose Clare Neelankavil, Trichur, India (in Patna, India)

JUBILARIANS

Congratulations to our three Medical Mission Sisters who celebrated their Silver Jubilees on February 11 1960.

Sister M. Elise Wijnen, M.D. from Baarn, Holland, Surgeon and Medical Director at Holy Family Hospital, Rawalpindi, West Pakistan, has spent 18 of the 25 years in the missions of India and Pakistan.

Sister M. Thomas De Villars, R.N. from Albany, N.Y., now in St. Michael's Hospital, Mymensingh, East Pakistan, has spent fifteen years in the missions.

Sister M. Theophane Shoemaker of Henshaw, Ky., is well known for her work with nurse midwives at the Catholic Maternity Institute, Santa Fe, New Mexico. At present Sister is working on the Holy Family Medical Center Building Program, Atlanta, Georgia.

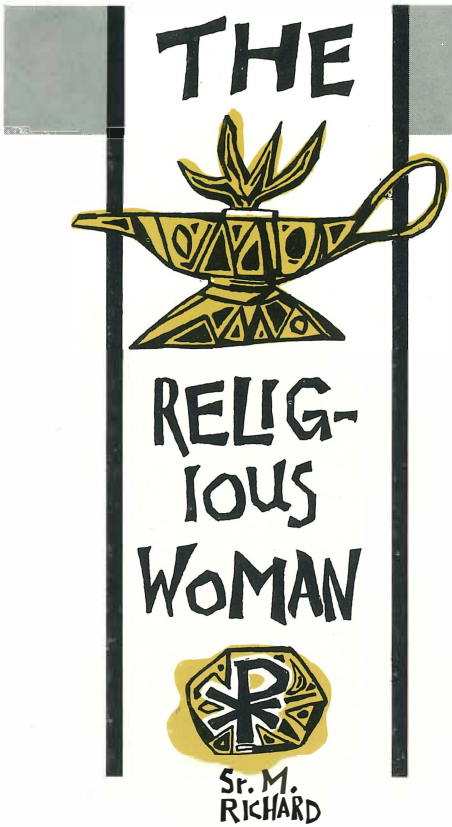
Please pray for our benefactors recently deceased: **R. I. P.**

Rt. Rev. Msgr. Timothy P. Sweeney, L.L.D., New Bedford, Mass.
Rev. Norman J. Johnson, Chicago, Ill.
Brother Rupert (Lawrence) Poudrier, Oconto, Wisconsin
Rev. Mother M. Gregory, O.P., Long Beach, N. Y.
Mrs. C. T. Alfafara, San Francisco, Calif.
Mrs. Mary F. Amaral, San Jose, Calif.
Mr. John T. Conroy, Richmond Hill, N. Y.
Mr. John J. Driscoll, Woodhaven, N. Y.
Mr. Frank Drum, San Francisco, California
Mrs. Mary C. Glatts, Philadelphia, Pa.
Mrs. Elizabeth L. Harrington, Washington, D. C.
Mrs. Margaret Kalab, Bellerose, N. Y.
Mrs. Flora M. Kelly, Philadelphia, Pa.
Mr. Joseph Keupp, Bellerose, N. Y.
Mrs. Richard Morrissey, Washington, D.C.
Mr. William Rea, Queens Village, N. Y.
Miss Gertrude C. Webb, Philadelphia, Pa.
Mr. Frank P. Withers, Oak Park, Illinois

"Above all be true religious . . . It is a truth of faith, . . . that virginity is superior to the married state, because the virgin soul binds itself in absolute and indescribable love directly with God—or rather with God incarnate, Jesus Christ . . .

Called by God to this chosen state through an ineffable design of love, you must be in actual fact, in spite of every obstacle, what you are by right.

You must be true spouses of the Lord; souls indissolubly and intimately united solely to Him. Souls without stain, detached from the world of the senses, from the world of money, the world of vanity . . ." Pius XII



Humanly speaking, the existence of our Society depends upon the knowledge and understanding that people have of our vocation . . . what we are, the work we do, our reasons for doing it. If young women are to choose this particular pathway to union with God and service to neighbor, they must first come to a knowledge, understanding and appreciation of our vocation. The Society will grow and fulfill its function in the world in the measure in which our vocation is understood and esteemed. It is for this reason that we continue this series of articles in explanation of "what we profess to be."

Medical Mission Sisters profess to be Religious Sisters, missionaries, servants of the sick. Our vocation is triune. Each element of this triple ideal is mutually related to the other but without the loss of integrity or dimunition of any one. For example, a Sister is not less a Religious because she is a doctor, nor is she less a doctor because she is a Religious. We can not separate these elements and say we are dedicated to God as Religious, to the Church as missionaries and to the sick as medical practitioners for the three are synthesized and fused in the mystery of the one vocation.

Every Medical Mission Sister, no matter what her task, no matter where it is performed, partakes of the fulness of this vocation which belongs to her by reason of her gift from God and her membership in the Society. If the Sister is not on foreign soil, she is no less a missionary. If she is not directly serving at the bedside of the sick, she is engaged in some activity, that this task of the Society, the care of the sick may be accomplished. All are, in truth, what their name implies, medical mission Sisters.

Our vocation can not be sectioned off in neat compartments, reserving the Religious part for one time, the mission-

ary and medical for other hours. It is one, every hour, every day, all the days of our life. However, for the purposes of explanation and in order to gain a greater appreciation of this vocation, we can give our attention to one facet of it at a time.

What does our Religious profession mean? On the day a Christian woman pronounces the vows of Religion, she ratifies and intensifies the vocation given to every one at Baptism. She does not take on a new set of Commandments but she pledges anew her desire to keep the ones incumbent upon all Christians. She stresses, with the total dedication of her life, *the one* we are all too small to encompass, too weak to completely fulfill. "Thou shalt love the Lord, Thy God with thy whole heart and whole soul and thy neighbor as thyself." The Religious life then is striving for the perfection of the Christian life. It is a directing of all one's faculties and energies to God to achieve closer union with Him by personal sanctity and to the expression of love for Him through service to neighbor.

The vows which bind a Medical Mission Sister to God, to His Church and to her own Society are the source of strength, the energizing force which gives dignity and inspiration and purpose to her life. The vows are paradoxical. They tie us tight yet they loosen us from the bonds of our own selfishness and greed and inordinate desires. They circumscribe our life yet they give a liberty and freedom to live for others. The vows offer unmeasured opportunity to love and to serve the universal Church, to play a part in extending Christ's Kingdom, to bring the message of their redemption to the hearts of men.

The vow of obedience enables us to remain one with the Will of God as it comes to us through the words of our superiors. Poverty keeps us from being chained to material things and grants freedom to go anywhere because one is not attached. Chastity allows us a virginity that can embrace motherhood unlimited and confirms singleness of purpose.

This profession of the vows of religion is the core of our medical mission vocation. It is the center and soul of it, the power and strength and joy of it. This consecration, this being set apart for God and the things of God, this being selected by the Almighty, this is the mystery which effects every bit of our being, dominates all our thoughts and actions and we are unable to explain it. This is the great grace that has come to us. No one is worthy, no one can initiate it. It is purely and simply, our gift from the heavenly Father who delights in choosing the weak to confound the strong.

YOUR WILL

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____for its purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

MISSION BOOKS

Sister M. Fabian, B. A.

FREEDOM AND REFORM IN LATIN AMERICA,
Edited by Frederick B. Pike.
University of Notre Dame Press,
1959. 308 pp. $6.00

In these days of increasing interest in Central and South America, there is a snowballing of books about our southern neighbors. The danger of superficiality grows greater with the increased volume. It is a joy to find a book which neatly avoids the danger and remains interesting.

Notre Dame's Professor Pike, in editing these papers, has highlighted the perennial problem of the relationship between freedom and law, as it applies to the Southern Hemisphere.

The contributors are all recognized scholars, historians, economists, anthropologists, sociologists and political scientists. All bring rich backgrounds to their individual studies.

This will be of interest to the scholar, but also to the casual reader who wishes to understand the complexities of political life south of our border.

THE COMMUNIST PERSUASION,
By Eleutherius Winance. Kenedy,
1959. 239 pp. $3.95.

In the last decade the term "brainwashing" has entered into and become a much used part of our vocabulary. While many writers have given personal descriptions of the experience of being "brainwashed," few have attempted to analyse the logic behind the method.

Father Winance, who personally underwent Hsio-Hsi, indoctrination, for a year and a half, describes the techniques which have brought about a tragic change in the Chinese people. Bringing to bear his training in philosophy, he points out the psychological processes involved and the effects on the individual. The strong emphasis on being at one with the group, conforming one's conscience, is illustrated in the custom of continual public confession of acts, and even interior thoughts.

In the second section, his own trial and expulsion are described and one is left with a feeling of great admiration. "See how these Christians love one another." It is inspiring to read of the sacrifices each missionary made for his companions in tribulation.

This book will explain to many of us how the people of China, among them Catholics, could have turned against the missionaries who worked so long for them. One wonders instead how any have been able to withstand the almost diabolical influences brought to bear.

MARYKNOLL BOOK OF PEOPLES,
By Albert J. Nevins, M.M. Crawley,
1959. 319 pp. $4.95.

A rich fund of knowledge of the peoples of the world, what they believe and how they live. Geography teachers will find it a colorful addition to youthful students' reading lists.

THE ECUMENICAL COUNCIL

ONE . . . THAT THE WORLD MAY KNOW

SISTER M. CUTHBERT, M. A.

All mankind is called by God to be ONE with an organic unity of life, God's own life, having ONE soul which is the Holy Spirit, ONE Head who is Christ and ONE glorious destiny which is the ecstatic consummation of the marriage of God and mankind at the end of time.

All mankind has heard this call, perhaps only in the inner yearnings of a restless heart, or as it reechoes in the *shahada* of the Moslem brotherhood*, fades into the silence of the Buddhist *nirvana* or inspires the bugle call of the Communist party slogan. All mankind, today, has heard the call to be ONE and it seems that all the world is looking for an answer to the call.

We who have the answer would gladly sing it out, clear and true, and carol it over all the earth but our voices are not heard by all mankind. It is not means of communication that are lacking today nor zeal nor good will. It is simply that the answer to the call for UNITY is itself divided before the non-Christian world. Many contradictory voices cry, "Here is Christ" or "See He is there" and the bewildered non-Christian world is not enticed to go out and see but stays soberly at home in its accustomed ways of life and worship.

It is because all mankind has been called to UNITY in Christ and is today readier than ever to answer the call, that the work of making Christians themselves more truly ONE, the work of the Ecumenical Council, becomes for each of us a missionary obligation.

We share Christ's priesthood when we offer the Eucharistic sacrifice on behalf of those who cannot offer it themselves. We must, therefore, also pray Christ's priestly prayer, first for all those who call themselves Christians that they in turn may pray it for all mankind, "that they all may be ONE . . . as we are ONE . . . that the world may know that Thou hast loved them."

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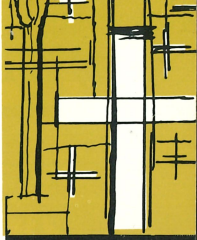
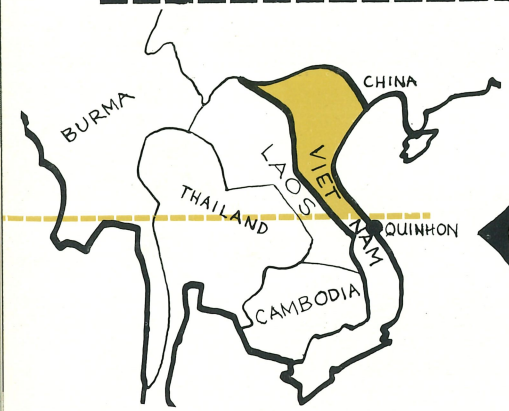
* Short creed of Muslims: There is no God but Allah, and Mohammed is His Prophet.



announcing a NEW



WHY A CATHOLIC HOSPITAL FOR QUINHON?

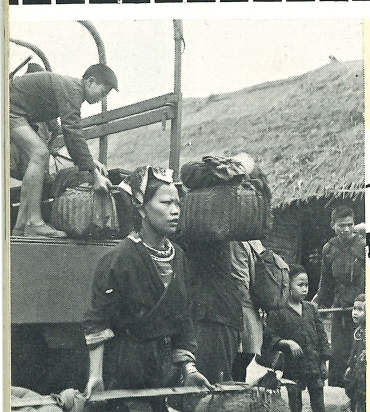
1. Quinhon was occupied for ten years by the Communists. They used the Cathedral for their headquarters. In 1954, before they left, after the Geneva agreement, they leveled the city to the ground.

2. Quinhon is now occupied by 50,000 heroic Vietnamese refugees who fled from the Communists in the north to South Vietnam—leaving behind their fields, homes, loved ones, all they possessed, walking 100 miles to freedom—in spite of danger, misery, hunger and disease—all for the right to continue their worship of God—to save their Faith.

3. Quinhon was the place where the missionaries first started their work back in 1583. Since then there have been 100,000 Vietnamese martyrs. Seventy-five of them are beatified.

4. Quinhon Diocese numbers 2,800,000 persons; 113,000 are Catholics, but there are 70,000 more waiting to come into the Faith—70,000 persons waiting for instruction, churches, missionaries, and hospitals.

5. Quinhon's medical needs are fantastic. There is no hospital, only one doctor for 50,000 persons—T.B., malaria, dysentery, amoebiasis, leprosy, and other diseases flourish there.



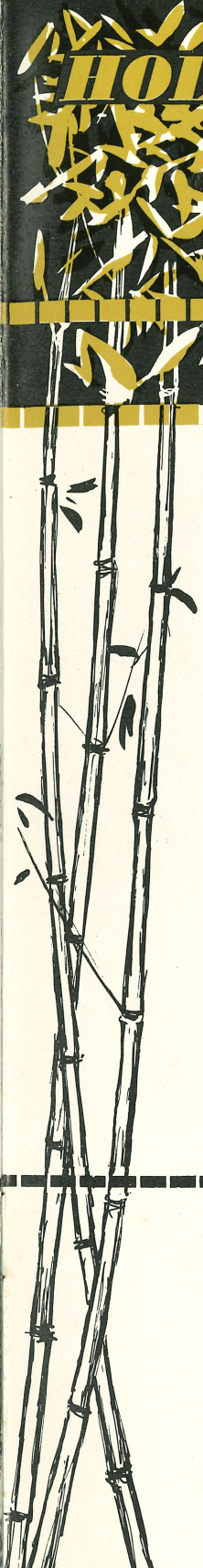
(Left)
Refugees fleeing from North Vietnam before Communists move in.

(Right)
Refugees start to build new homes in S. Vietnam.

HOLY FAMILY HOSPITAL

to be opened by the
MEDICAL MISSION SISTERS

Quinhon, S. VIETNAM



WILL YOU HELP US BUILD AND EQUIP A 50-BED GENERAL HOSPITAL FOR THE REFUGEES IN VIETNAM? While they are still fighting the Communist foe to the North, and in their midst they deserve all the help we can give them—these Brothers of ours in Christ.

We are starting with NOTHING . . . We need EVERYTHING: a building, beds, chairs, linens, mattresses, medicines, instruments, a chapel, etc.

WILL YOU HELP US IN S. VIETNAM NOW?

MEDICAL MISSION SISTERS, Philadelphia 11, Pa.

Dear Sisters:

Here is my gift $_____ for your hospital in Vietnam.

Name _____

Address _____

City_____ Zone_____ State_____

Mary in the Gospels

Now in those days Mary arose and went with haste into the hill country to a town of Juda.
Luke 1:39.

(One of a series)